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FISCAL IMPACT STATEMENT

LS 6788 **NOTE PREPARED:** Jan 7, 2010
BILL NUMBER: SB 414 **BILL AMENDED:**

SUBJECT: Providers of State-Administered Health Care Programs.

FIRST AUTHOR: Sen. Mishler **BILL STATUS:** As Introduced
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: This bill allows the Office of the Secretary of Family and Social Services (FSSA) to exclude specified persons who engage in fraud or abuse from participating in state-administered health care programs. The bill requires FSSA to maintain a list of persons excluded from participating in state-administered health care programs and provide that list to specified persons.

The bill also requires a Medicaid provider or applicant to submit a $50,000 surety bond to the Office of Medicaid Policy and Planning (OMPP) to be used for specified purposes before the provider may receive reimbursement.

Effective Date: July 1, 2010.

Explanation of State Expenditures: The bill would allow FSSA to exclude specified providers or persons who engage in fraud or abuse from participating in state-administered healthcare programs such as Medicaid, CHIP, CHOICE, Children with Special Health Care Needs, and Medicaid for residents of county homes. FSSA would be required to maintain a list of the providers excluded from state-administered programs including Medicaid. The list is to be made available to other health care providers. The list could be maintained on the Indiana Health Coverage Programs web page. The Medicaid Fraud Unit operated by the Attorney General would be involved in the development of the list of providers excluded from state-administered programs as the agency that investigates Medicaid provider fraud. The personnel resources needed to develop and maintain the list are not known at this time.

FSSA would also need to promulgate rules prescribing how a provider that has been excluded from participation in the state-administered health care programs may be reinstated. Promulgation of rules is

considered to be a routine administrative function that may be accomplished within the current level of resources available to the agency.

The Attorney General's Office operates the Medicaid Fraud Unit which investigates provider fraud in the state. The bill does not assign administrative responsibility for state-administered program fraud specifically. A large number of providers for state-administered programs are also Medicaid providers. There is currently no provision in state law that would prevent a provider that is excluded from participating in the Medicaid program from claiming reimbursement from another state-operated health care program. However, providers convicted of Medicaid fraud may have professional licenses revoked or suspended and persons convicted of abuse would be prevented from providing services in other state-operated programs by requirements for background checks.

Surety Bond Requirement: The bill would after July 1, 2010, require all applicants for Medicaid provider status to furnish a $50,000 surety bond with the application. Current Medicaid providers would have until October 15, 2010, to provide FSSA with the required surety bond. The bill provides that if a surety bond does not meet the specified requirements, OMPP may revoke or deny the provider's billing privileges. If a lapse or gap in bond coverage occurs, OMPP is required to revoke the provider's billing privileges. The bill provides that OMPP may not reimburse a Medicaid provider for services provided during the lapse or gap in coverage. The level of resources required by FSSA and OMPP to implement the surety bond requirement for Medicaid providers is not known at this time.

Explanation of State Revenues: *Surety Bond Requirement:* By requiring surety bonds for all Medicaid providers, OMPP could increase recoveries for overpayments and reimbursements made for fraudulent claims. OMPP estimated in FY 2008, that the overpayment balance was in excess of $24 M.

The bill would require all Medicaid providers to furnish OMPP with a $50,000 surety bond before the provider can receive reimbursement. The Centers for Medicare and Medicaid Services (CMS) has estimated the average annual cost of a surety bond at 3% of its face value, or about $1,500 for a $50,000 bond. Generally, surety bond cost is related to individual factors relating to the bondholder's risk, such as credit rating, length of time in business, or prior adverse actions, so bond prices would vary depending on the buyer. If a Medicaid provider has had an adverse judgement or final order related to Medicaid provider services within the preceding 10 years, the bill requires an additional $50,000 surety bond.

The bill appears to require all Medicaid providers to furnish a bond without making a distinction between the level of billable claims that would be submitted by different types of providers. It is assumed that an managed care organizations (MCOs) or a hospital would be required to provide the same level of bonding assurance as would an independent dentist, optometrist, or personal care assistant.

Background Information: Medicaid providers range from MCOs, hospitals, and nursing facilities to sole healthcare practitioners and service providers. State contracts with the MCOs currently require the organizations to provide a bond in the amount of $1 M. It is not known how many other contracted Medicaid providers are required to provide a bond as a term of the contract. Medicare regulations require certain other providers to furnish surety bonds for Medicare purposes; home health agencies are required to furnish surety bonds to Medicare and Medicaid.

Explanation of Local Expenditures: Local government-owned hospitals and health facilities that bill Medicaid would be required to provide surety bonds for Medicaid participation. It is not known if clinics

operated by local health departments or a health and hospital corporation bill Medicaid for services. The provision would apply if a clinic submits claims for Medicaid reimbursement.

Local school corporations are required to apply for Medicaid provider status. Some school corporations bill for Medicaid services; others do not.

Explanation of Local Revenues:

State Agencies Affected: FSSA; OMPP; Attorney General's Office.

Local Agencies Affected: Local government-owned hospitals and health facilities, local school corporations, and potentially local health departments or a health and hospital corporation.

Information Sources: FSSA, MCO contracts, CMS State Medicaid letters and CMS Press Releases.

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